Illinois Comprehensive Health Insurance Plan
400 West Monroe Street, Suite 202
Springfield, Illinois 62704-1823
217-782-6333 or 800-962-8384
www.chip.state.il.us

Standard Authorization to Use or Disclose Protected Health Information (PHI)

Section A: The individual for whom this authorization is being requested. Please complete the following:

Name: First M Last | Group # | Identification #

Social Security Number | Date of Birth

Address | City | State | ZIP

Area Code & Telephone Number | E-mail Address (if available)

Section B: Please place an "X" in the box next to each category of specific Protected Health Information to disclose. (You may mark as many boxes as appropriate.)

☐ Any and All Information about my CHIP Coverage ☐ Claims ☐ Premium Payment/Billing History
☐ Eligibility and Enrollment ☐ Other (describe): _____

Section C: Describe the reason for the release or request of information.

☐ At my request ☐ Other (describe): _____

Section D: Who will provide this information?

Name CHIP and its Plan Administrator
Address 400 W. Monroe, Suite 202
Springfield, IL 62704-1823
Relationship Health Plan

Section E: Who will receive this information?

Name _____
Address _____
_____
Relationship _____

Section F: Please place an "X" in the box next to the date or event that describes when your authorization will expire. (Please mark only one box.)

☐ Upon Revocation ☐ 1 year after my death ☐ 1 year after my CHIP coverage ends
☐ A specific date: _____ ☐ Other (describe): _____
Month Day Year

Section G: I understand that:

- This authorization will expire on the date or event listed in Section F above.
- This authorization is voluntary.
- Payment, enrollment or eligibility for benefits for my health care will not be affected if I do not sign this form.
- I may revoke this authorization at any time by notifying in writing the company/individual listed in Section D from providing the PHI identified in this authorization, but if I do revoke this authorization, it won't have any affect on any actions the Comprehensive Health Insurance Plan took before they received the revocation.
- Information disclosed as a result of this authorization may no longer be protected by federal privacy laws and may be disclosed by the company or individual receiving the information.
- I should retain as my copy one of the duplicate authorization forms I received.

Section H: Signature.

I hereby authorize the use or disclosure of the Protected Health Information as described in Section B pertaining to the Individual listed in Section A.

Signature of Individual or Individual's Personal Representative | **Date: month/day/year**

Section I: If Section H is signed by a Personal Representative, please complete the information below:

Personal Representative's Name | **Relationship to Individual**

Personal Representative's Address | **City** | **State** | **ZIP**

Personal Representative's Area Code & Telephone Number | **Personal Representative's E-mail Address (if available)**

Use this form to give us permission to provide your Protected Health Information (PHI) to a spouse, other relative or a friend.

In compliance with the privacy regulations under the federal Health Insurance Portability and Accountability Act (HIPAA), CHIP and its Administrator will only be able to release PHI to you, providers, and others directly involved in Treatment, Payment, and Healthcare Operations (TPO). We will not be able to release PHI to anyone else without your authorization to do so. If you would like us to discuss any aspect of your CHIP coverage or application with someone else, you must authorize us to do so by sending us this completed and signed CHIP Authorization Form. Please refer to your CHIP Notice of Privacy Practices document for more details about HIPAA.

INSTRUCTIONS

NOTE: If an incomplete or unsigned form is received, we will not discuss your PHI with the person(s) named on the front of this form. Call 800-962-8384 if you have any questions.

SECTION A: Print the CHIP participant's name, address, phone number, group number, identification number, date of birth, and e-mail address (if available). If you are not yet enrolled, use your Social Security number as your identification number and leave the group number blank.

SECTION B: Describe the specific information you authorize us to disclose to the person listed in Section E.

SECTION C: Describe the reason for the request of information.

SECTION D: This section typically contains CHIP and its Plan Administrator's name and address. If you want to use this form to authorize another entity other than CHIP to disclose your PHI, be aware that this form may not be acceptable to that other entity.

SECTION E: Indicate the name and address of the person you authorize to obtain information about your CHIP coverage. You also need to describe the relationship of that person to you.

SECTION F: Provide the date or event upon which the authorization will expire.

SECTION H: After reading Section G, the Participant/applicant must sign and date this section.

SECTION I: Only complete this section if someone other than the Participant (e.g. Power of Attorney) is requesting the authorization. Remember to submit the appropriate legal documentation, if it is not already on file with our office.

Please complete and sign both copies of the form and keep one for your records. **You may access this form on our web site by going to www.chip.state.il.us/hipaaformhtm. Complete the form, then print it, sign and date it.** Return the other completed/signed form to:

Illinois Comprehensive Health Insurance Plan
400 West Monroe Street, Suite 202
Springfield, Illinois 62704-1823